STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445160	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD REHABILITATION CENTER	200 MAYFIELD DRIVE SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect the corridor. The finding included: Observation of the north corridor on 5/20/13 at 9:31 AM, revealed the door to the soiled utility room wedged open. This finding was verified by director of maintenance and acknowledged by the administrator during the exit conference on 5/20/13.	K 021	1. Wedge removed allowing for door to positively latch. 2. All doors have been checked for compliance. 3. Proper door closures will be added to the facilities weekday compliance rounds. Compliance rounds are conducted by facility manager on a weekday basis. Documented compliance is provided; any deficits are reported to the discipline assigned to correction. 4. The Maintenance Supervisor will be responsible for monitoring the compliance. Compliance will be supported by evidence of weekday compliance rounds. Audit of these rounds will produce monthly outcomes that will be reported to monthly Quality Assurance Committee. Any non-compliance will require plan of correction as reported to the quality assurance committee. The Quality Assurance Committee consists of Medical Director, Administrator, Director of Nurses, Activity, Housekeeping/Laundry Supervisor, Director of Rehab, Social Services, Unit Nurse Manager (2), and any other disciplines deemed necessary at this time.	6-14-13 6-14-13 6-14-13 6-12-13 6-12-13
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debbie Bowers	Administrator	6/13/13

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 14 2013

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K 052	Continued From page 1 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on records review, it was determined the facility failed to provide documentation of the annual fire alarm test. The finding included: Document review on 5/20/13 at 10:05 AM, revealed documentation for the fire alarm test for the year 2012 was not available. This finding verified by the director of maintenance and acknowledged by the administrator during the exit conference on 5/20/13.	K 052	1. The Annual fire alarm test was conducted on 11-12-12. A copy of the report was obtained and faxed to the Tennessee Department of Health, per TDH request. 2. /3. All required contracts attributable to the facility plant will be plotted on a monthly calendar. This information will be brought to the quarterly Quality Assurance Committee for review and for compliance that service was provided as scheduled. 4. The Maintenance Supervisor will be responsible to keep the monthly calendar updated and to present to the QA committee compliance with scheduled plant services.	5-20-13 2:39pm 6-17-13 6-17-13
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, it was determined the	K 069		

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K 069	Continued From page 2 facility did not protect the cooking facilities. The finding included: Observation of the kitchen on 5/20/13 at 8:44 AM, reveled the deep fat fryer was not protected by the hood suppression system. This finding was verified by the director of maintenance and acknowledged by the administrator during the exit conference on 5/20/13.	K 069	1. The deep fat fryer was relocated to allow for full coverage under the hood suppression system. 2. All Kitchen requirements were reviewed to assure compliance with hood coverage. No other deficiency found. 3. No new equipment will be allowed in kitchen without approval of facility, as well as corporate maintenance personnel, to ensure that cooking equipment is located under hood suppression system. 4. Audit of the kitchen equipment will be placed on the weekday compliance rounds that are completed by facility managers. Any non-compliance issues will be reported to the Maintenance Supervisor for correction.	5-27-13 5-21-13 5-27-13 6-14-13
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to provide a remote annunciator for the generator. The finding included: Observation of the nurses station on 5/20/13 at 9:00 AM, it was revealed there was no remote generator annunciation. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/20/13.	K130	Contact local electrician to locate a remote annunciator panel at the north nurses station for the facility generator.	7-6-13
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	1. Multi plug adaptor was replaced. Hair dryer plug was replaced.	5-20-13 5-20-13

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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain electrical equipment. The finding included: Observation of the beauty shop on 5/20/13 at 9:22 AM, revealed a damaged plug on the hair dryer and the use of a multi plug adaptor. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/20/13.	K 147	2. A complete audit of the building was completed for any inappropriate electrical cords and plugs. No further deficiencies were found. 3. Appropriate electrical cords and conditions of cords were added to the weekday compliance rounds completed by facility managers. Any non-compliant findings will be referred to the Maintenance Supervisor for correction. 4. The weekday outcomes will be included in the monthly Quality Assurance meeting. Any deficient practice and /or trends will be reported along with a plan of action to address these deficient practices. The Maintenance Supervisor will be responsible to remain in compliance with repairs as necessary.	6-14-13 6-14-13 6-17-13

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